No. 16,130

IN THE

United States Court of Appeals

For the Ninth Circuit

METROPOLITAN LIFE INSURANCE COMPANY, a corporation,
Appellant,

vs.

MARGARET L. GRANT,
Appellee.

Appeal from the United States District Court for the Northern District of California, Southern Division.

BRIEF OF APPELLANT.

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STATEMENT CONCERNING JURISDICTION.

This civil action, based upon an alleged contract of insurance, was removed from a Superior Court of California to the U. S. District Court for the Northern District of California, Southern Division, San Francisco, on the grounds of complete diversity of citizenship and the matter in controversy exceeding the sum of $3,000.00, exclusive of interest and costs. (R. 3-18.) See Title 28 U.S.C. §§ 1441; 1331 and 1332(a) and 1332(a)(1).

The first cause of action of the First Amended Complaint (R. 23-25) was dismissed on May 27, 1957. (R. 34.) The remaining second and third causes of action of the First Amended Complaint and Appellant's Answer thereto (R. 25-34) show complete diversity of citizenship and that the matter in controversy exceeds the sum of $3,000.00, exclusive of interest and costs.

The statutory provisions sustaining jurisdiction of the District Court are Title 28 U.S.C. §§ 1332(a) and 1332(a)(1).

Thereafter, a Final Judgment was entered (R. 43-45) and an Appeal therefrom was taken by the Appellant herein to this Court. (R. 45.)

The statutory provisions sustaining the jurisdiction of this Court to review the Judgment are Title 28 U.S.C. § 1291.

STATEMENT OF THE CASE.

This is a case of first impression under California law. There is no California case precisely on this situation.

The action was tried on the issues raised by the Second and Third Causes of Action of Appellee's First Amended Complaint and Appellant's Answer thereto. (R. 25-28; 34; 32-34.)

Said action is based on an alleged written contract of insurance purported to have been made between Appellant and Appellee's former husband, Peter Grant, on August 11, 1954, in Watsonville, California,

consisting of a written application and a receipt. (Exhs. 1 and 2; R. 244-244D and 245; see also full size photo of Ex. 1.) Actually, the documents were signed on August 10, 1954. (R. 57-63.)

Appellee alleges in her said Second Cause of Action that Appellant had "previously secured from its home office an approval of said contract of insurance for the class, plan and amount of insurance provided for in said contract." (R. 26.)

Judgment was entered for Appellee requiring Appellant to pay her $34,000.00 as specified therein, plus interest on installments and costs. (R. 43-45.)

In June, July and part of August of 1954 Appellee and her then husband, Peter Grant, lived in Watsonville, California. He was a crop-duster pilot for the Atwood Crop Dusters of Salinas, California. He and Appellee operated the business in Watsonville. (R. 141.) His annual income was $15,000.00 per year. (R. 198; Exhibit 1, R. 244C.) He died in the morning of August 13, 1954. (R. 107.) Appellee remarried on November 10, 1956. (R. 128.)

George I. Price was a soliciting agent of Appellant and worked out of Appellant's Monterey District Office as a "detached" agent in the Watsonville area collecting premiums and soliciting new insurance. Insurance business handled by Price came through the Monterey District Office (R. 158) and from there to the head office in San Francisco. (R. 175-176.)

Price called on Grant at his home a number of times during June, July and August (the last being

August 10) of 1954, to discuss insurance. Some of the times Appellee was there, and other times she was not. The dates of the meetings are not clearly within the recollection of Appellee or Price. (R. 129-133; and R. 212, next to last line.) On August 10, 1954, there was the final meeting at Grant's home. Appellee was present. (R. 57-58.) Grant wanted insurance. Price had Appellant's form of application for life insurance with him. He asked Grant the questions contained in Part A of the Application. Grant answered the questions and Price wrote down the answers in his handwriting on Part A of the Application. (R. 58-59.) After Price had filled in Part A of the Application, he had Grant read it over. Then Grant signed Part A and Price signed as a witness to Grant's signature. (R. 217-218.) Margaret L. Grant is named as beneficiary in the application. (Ex. 1, Part A, No. 19(a); R. 244, No. 19(a).) The agent asked for $53.36. (R. 60.) At the request of Grant, Appellee drew a check for that sum on the Bank of America, Watsonville, California, payable to Appellant. (R. 105.) The Application, Part A of which was filled in by Price and signed by Grant and Price, and dated August 11, 1954, is Plaintiff's Exhibit 1. (Seven actual size photostatic copies of this exhibit have been filed with this Court for its convenience. It is reproduced (but not in actual size or form) in the Record at pages 244 through 244C, inclusive.) The check was dated August 11, 1954, for the reason that, on August 10, 1954, Grant's bank account did not have sufficient funds to cover the check and, at the request of Peter

Grant and Appellee, Price agreed to hold the check until later. Funds sufficient to cover the check were deposited in the account on August 11, 1954. (R. 103.)

At the meeting on August 10, 1954, Price told Grant he would have to have a medical examination for the insurance and that Appellant's examining physician in Watsonville was Dr. Blaisdell. He asked Mr. Grant if he could see Dr. Blaisdell on August 11, 1954, but Grant replied that he was very busy and couldn't make it. Price suggested, inasmuch as Grant was working when he was called upon to do so, depending upon flying conditions and so forth, that he make his own appointment. Price could not get any definite time from Grant as to when he could see the doctor. (R. 72-75.)

Price wrote out a receipt for $53.36. When he filled it in it was attached to the Application. (R. 218.) In the lower left hand corner of the receipt, following the printing "Appointment for Medical Examination", Price wrote "1st—small office"; following the printed word "Date", he wrote "not Thurs.", and below that he wrote "Dr. Blaisdell". (Ex. 2, R. 245; R. 71-72.)

(*Note:* The correct name is Blaisdell. Variation in spelling was due to use of different reporters in the trial court. "Dr. Blaisdell" and "Dr. Blaisdale" are one and the same person.)

Appellee's own testimony is as follows:

(Mr. Brauer, on direct examination):

"Q. Was anything said in that meeting with regard to a medical appointment?

A. Yes, Mr. Price told Mr. Grant that he would have to go to Dr. Blaisdale and have his physical examination.

Q. What else was said?

A. But that he couldn't go on Thursday because that was Dr. Blaisdale's day off." (R. 105-106.)

On cross-examination by Mr. Walsh she testified:

"Q. On this same occasion, August 10th, did you hear Mr. Price tell Peter Grant that *he had to have a medical examination for this insurance?* (emphasis ours)

A. Yes, I did.

Q. And that he was to go and see Dr. Blaisdell, is that correct?

A. That's correct.

Q. And you yourself, I believe, testified that you went to Dr. Blaisdell's office and made an appointment for your husband to be examined for this insurance, and you made the appointment for him to see Dr. Blaisdell on August 13th of 1954 at 3:30 p.m., is that correct?

A. That's correct.

Q. And you made that appointment on Thursday, the 12th of August?

A. That's correct.

Q. And before Peter Grant went to Dr. Blaisdell for the medical examination for this insurance, he died?

A. That's correct." (R. 130.)

After the receipt was filled in by Price, he gave it to Grant at the time Grant handed the check to him. (R. 105.) The receipt is Plaintiff's Exhibit 2, reproduced at R. 245.

Neither on August 10, 1954, nor at any other time, did Price make any representation as to when insurance would be effective. This fact is likewise established by Appellee's own testimony. She testified on direct examination:

(Mr. Brauer):

"Q. Was anything said at that time as to when coverage was to be effective?

A. No, he didn't say either way." (R. 106.)

On cross-examination she testified:

(Mr. Walsh):

"Q. Thank you. Reading from the deposition of Margaret L. Grant, taken on March 28, 1956, lines 1 to 4, page 80: 'Q. There was no representation made at that time on August 10th by Mr. Price or at any other time as to when this insurance would become effective? A. No.' Do you recall that question?

A. Yes, I do.

Q. And you recall giving that answer?

A. Yes, I do.

Q. Is that your testimony now?

A. Yes." (R. 129-130.)

After August 10, 1954, Price took the application to Dr. Blaisdell's office and left it there. (R. 235.) On August 12, 1954, Appellee made an appointment for her husband for the medical examination by Dr. Blaisdell. She testified concerning this on direct examination:

"Mr. Brauer. Q. Did you do anything with regard to a medical appointment for your husband?

A. Yes. On Thursday I had to take our son up, spent all day in the same building——

Q. Pardon me, I didn't hear you, I'm sorry.

A. On Thursday, which was the 12th, I had an appointment in the same building as Dr. Blaisdale for my oldest boy, and I was there all day, and while I was there I went to the desk and made an appointment for Mr. Grant for Friday. They couldn't take him until 3:30 that afternoon, which would be the 13th." (R. 107.)

On cross-examination Appellee gave similar testimony:

(Mr. Walsh):

"Q. And you yourself, I believe, testified that you went to Dr. Blaisdell's office and made an appointment for your husband to be examined for this insurance, and you made the appointment for him to see Dr. Blaisdell on August 13th of 1954 at 3:30 p.m., is that correct?

A. That's correct." (R. 130.)

On August 14, 1954, the day after Grant died, Price called at the Grant home and returned the check for $53.36 to Appellee and she accepted it. Since that date no tender of any amount of money has ever been made to Appellant on account of the premium, either by Appellee or her attorneys. (R. 134-135.)

After Grant's death, Price picked up the application (Ex. 1) from Dr. Blaisdell's office and sent it to Appellant's Monterey District Office. (R. 235.) The application was sent from the District Office to Appellant's Pacific Coast Head Office along with a letter dated August 20, 1954. (R. 189-191; Dft's Ex. G.)

FACTS RELATING TO QUESTION OF PRIOR APPROVAL.

In June a "trial application" concerning $5,000.00 insurance on the "Whole Life Paid-Up at Age 85 Plan" was submitted to the head office. This was on the same type of form as Ex. 1 but was not a regular application for insurance because the word "Trial" was written on the form. (R. 207-208.) This unsigned trial application was sent by the Manager of the Monterey District Office to Appellant's Pacific Coast Head Office with a written request, dated June 28, 1954, for advice as to whether a regular application for such a policy could be submitted and what the extra aviation premium would be. (R. 173-175; Ex. A, R. 250.) Jonas Svendsen, Appellant's Chief Underwriter at its Pacific Coast Head Office (R. 219), replied by letter, dated July 6, 1954 (Ex. B, R. 251), advising that, before a trial application could be given further consideration and the proper aviation premium quoted, it would be necessary to complete Appellant's Aviation Questionnaire and submit it to the Head Office. This letter, as well as all other letters from Appellant's Head Office were sent to the Monterey District Office. (R. 171-191.) An Aviation Questionnaire was completed (Ex. 5, R. 248) and sent from the District Office to the Head Office with a letter dated July 15, 1954. (R. 178; Ex. C, R. 252.) Jonas Svendsen, by letter dated July 20, 1954 (Ex. D), advised the District Office that Appellant *could consider* the prospect for insurance with a basic extra annual aviation premium of $20.00 per $1,000.00. This letter stated, in part:

> "We suggest, therefore, that if our tentative offer is acceptable that you complete the application, arrange for a medical examination between Mr. Grant and one of the authorized examiners in your territory and order the mercantile report in the usual manner. This must not be construed as a promise to issue as we can make no definite offer until we have viewed the completed papers. If an application is submitted, please refer to this correspondence. We are returning herewith the trial application for whatever disposition you care to make of it."

This letter of July 20, 1954, was sent by the District Office to Price (R. 182) and was shown by him to Grant (R. 193-194). The trial application was lost. (R. 207.)

Appellant's Monterey District Office, by letter dated July 26, 1954, requested the Head Office to advise of the amount of extra aviation premium on the term element of a policy on "Family Income with Whole Life paid-up at age 85." The District Office wrote "The prospect is interested in $5,000.00 on the above plan". (R. 183-184; Ex. E, R. 254.) Jonas Svendsen wrote to the District Office, by letter dated July 30, 1954, advising of the method to compute the basic extra annual aviation premium on the plan mentioned. Alan Wigham, Manager of Appellant's Monterey District Office, wrote on the bottom of the July 30, 1954, letter as follows:

> "$20.00 for life paid-up at 85 or other plans except Family Income.

For Family Income $40.00 per $1,000.00—

With $1,000.00 and $20.00 per month $60.00 per $1000

Better stick to a straight plan of insurance—no Family Income." (R. 184-189; Ex. F, R. 255.)

This letter was sent to Price (R. 188) and he showed the letter to Grant (R. 194).

After the death of Grant, the District Office advised the Head Office of the fact by letter dated August 20, 1954, and attached to this letter the application which had been partly filed in on August 10, 1954. (R. 189-191; Ex. G, R. 256.) At the trial, Appellant offered into evidence a form of policy which would have been issued by Appellant if the application had been completed and approved and the full first monthly premium had been paid. It was admitted into evidence with the typewritten portions of it stricken. (R. 229-234; Ex. H.) Appellant has supplied seven true and correct copies of Exhibit H for the convenience of the Court.

STATEMENT OF QUESTIONS INVOLVED AND THE MANNER IN WHICH THEY ARE RAISED.

The questions involved are:

1. Was there a written contract, consisting of Appellee's Exhibits 1 and 2, whereby the life of Peter Grant was insured at the time of his death on the morning of August 13, 1954?
2. Did the Appellant, prior to August 10, 1954, approve, at its home office, the said alleged

contract of insurance for the class, plan and amount thereof?

The manner in which the foregoing questions are raised is as follows:

The facts on which the questions are based appear in the evidence adduced at the trial. The Findings of Fact and Conclusions of Law of the District Court adverse to Appellant and the Judgment of the District Court are erroneous, unsupported by the evidence, and contrary to law.

SPECIFICATION OF ERRORS.

Error No. 1. The Court below erred in rendering the final Judgment heretofore entered (R. 43-45) on the ground that it is against the law.

Error No. 2. The Court below erred in rendering said Judgment (R. 43-45) on the grounds that it is not supported by the evidence and is contrary to the evidence.

Error No. 3. The Court erred in finding as a fact, in Finding of Fact No. II (R. 38), that "plaintiff is . . . the beneficiary named in the *contract of insurance* sued upon", on the ground that said finding is erroneous and not supported by the evidence, and the term "contract of insurance" is a misplaced conclusion of law. (Emphasis ours.)

Error No. 4. The Court erred in finding such broad agency of Price as set forth in Finding No. IV (R.

39), including the authorization "to take such applications" and "to give *binder* receipts" (emphasis ours) on the ground and for the reason that it is clearly erroneous and, in this particular case, the limitation of authority of the agent is set forth in writing.

Error No. 5. The Court erred in making the following portion of Finding of Fact No. V (R. 39):

> "In the course of said period of time and in pursuit of said solicitation the defendant fully informed itself of Peter Grant's needs and desires for life insurance and of his occupation and other factors bearing upon his acceptability as an insurance risk and the terms upon which such risk would be assumed by defendant."

on the ground it is erroneous and is not supported by the evidence.

Error No. 6. The Court erred in making the finding, in Finding No. VI (R. 39):

> "At all times herein mentioned up to and including August 13, 1954, Peter Grant enjoyed excellent health and suffered from no disability, infirmity or ailment."

on the ground that such finding is erroneous and contrary to the evidence.

Error No. 7. The Court erred in finding, in Finding of Fact No. VII (R. 39-40), that:

> "On or before August 10, 1954, defendant, at its head office, authorized and approved Peter Grant for insurance as to the business in which he was engaged."

on the ground that such finding is erroneous and contrary to the evidence.

Error No. 8. The Court erred in making Finding of Fact No. VIII (R. 40) on the grounds that it is erroneous and contrary to the evidence and does not fully and fairly state the facts as to what occurred on August 10, 1954.

Error No. 9. The Court erred in making Finding of Fact No. IX (R. 40) as follows:

> "Plaintiff and Peter Grant and each of them at all times construed the application and the binder receipt as effecting a contract of insurance upon the life of Peter Grant in accordance with the terms set forth in said documents immediately upon signing Part A of said application and delivery of said sum of $53.36. Said construction was reasonable."

on the ground that the facts stated therein are clearly erroneous and contrary to the evidence and the finding contains conclusions of law.

Error No. 10. The Court erred in making Finding No. X (R. 40-41) as follows:

> "At no time prior to the death of Peter Grant did the defendant perform any act or communicate an intention to rescind or terminate said contract of insurance."

on the grounds and for the reason that said finding is unnecessary and immaterial and is not supported by the evidence.

Error No. 11. The Court erred in finding as a fact that portion of Finding No. XI (R. 41) that Peter

Grant died "solely as the result of an accident while engaged in his occupation hereinbefore mentioned." because said finding is erroneous and not supported by the evidence and is not an issue in this case.

Error No. 12. The Court erred in finding that portion of Finding No. XII (R. 41) which reads "Said contract of insurance provided" because said finding is erroneous and not supported by the evidence and also because said finding is a misplaced conclusion of law.

Error No. 13. The Court erred in failing to make any finding on a material issue, as set forth in Paragraph 13 at page 238 of the Record.

Error No. 14. The Court erred in failing to make any finding on a material issue, as set forth in Paragraph 14 at page 238 of the Record, on the grounds that such a finding is supported by the evidence and is material to the issues in this case.

Error No. 15. The Court erred in failing to make a finding on a material issue, as set forth in Paragraph 15 at pages 238 and 239 of the Record, on the grounds that such a finding is supported by the evidence and is material to the issues in this case.

Error No. 16. The Court erred in failing to make a finding on a material issue, as set forth in Paragraph 16 at page 239 of the Record, on the grounds that such a finding is supported by the evidence and is material to the issues in this case.

Error No. 17. The Court erred in failing to make a finding on a material issue, as set forth in Para-

graph 17 at page 239 of the Record, on the grounds that such a finding is supported by the evidence and is material to the issues of this case.

Error No. 18. The Court erred in its Conclusion of Law No. II (R. 41-42) as follows:

> "On August 10, 1954, a contract of insurance upon the life of Peter Grant was entered into between Peter Grant and the defendant, said contract was dated August 11, 1954, and was to take effect on said date. The provision in said contract with regard to approval of the risk at the defendant's home office was a condition subsequent; i.e. Peter Grant was insured from the date of the contract subject to the right of the defendant during the life time of the insured to return the premium paid and to communicate its disapproval of the risk and thereby to terminate the contract."

on the grounds and for the reason that it is erroneous and against the law and is not supported by the evidence.

Error No. 19. The Court erred in its Conclusion of Law No. III (R. 42) as follows:

> "Said contract was in full force and effect on August 13, 1954, the date of Peter Grant's death."

on the grounds and for the reason that it is erroneous and against the law and is not supported by the evidence.

Error No. 20. The Court erred in its Conclusion of Law No. IV (R. 42) as follows:

"Plaintiff and Peter Grant have each performed all the terms and conditions of said contract by each agreed to be performed."

on the grounds that it is erroneous and against the law and is not supported by the evidence.

Error No. 21. The Court erred in making Conclusion of Law No. V (R. 42-43) in concluding that the defendant was obligated to pay any money to plaintiff, on the grounds that there was no contract under which the defendant was obligated to pay anything to the plaintiff and on the grounds that said conclusion is erroneous and against the law and is not supported by the evidence.

Error No. 22. The Court erred in not granting defendant's motion to strike the opinion of Dr. Sambuck as to the medical acceptability of Peter Grant as a standard insurance risk on June 8, 1954, and it erred in failing to sustain all other objections by defendant to Dr. Sambuck's testimony. The grounds urged for the objection and the full substance of the evidence admitted are as follows (R. 119):

"Mr. Brauer. Q. After making this examination, will you state what those findings were with regard to the health of Peter Grant at that time?

Mr. Walsh. Just a moment.

Mr. Brauer. Q. Based on your examination?

Mr. Walsh. I think that is immaterial, Your Honor, as to what the condition of his health was on June 8th, 1954.

The Court. I will make the same ruling I have made on the admission of other testimony.

I will let it in and I will rule on its admissibility later.

Mr. Brauer. Q. You may answer the question.

A. I found him in good physical health."

Dr. Sambuck testified that he had acted as a medical examiner for several life insurance companies. Then the following testimony was elicited (R. 120-122):

"Q. Now and as such, you have had occasion, have you not, to determine the medical acceptability of an applicant for life insurance. Now, based on your examination of Peter Grant, on June 8th, and on your experience as a life insurance medical examiner, do you have an opinion as to whether Peter Grant was, on June 8, 1954, a medically standard insurance risk?

A. Yes.

Mr. Walsh. Just a moment, please. I ask that that answer be stricken, because the question is not involved here as to whether on June 8th of 1954 this man, this applicant, would have been eligible, and furthermore, the hypothetical question does not take into consideration all the facts and issues in the case; and for the further reason that it is anticipating something that is not in evidence.

The Court. I will let him answer this question. Just yes or no.

A. Yes, sir, I do.

Mr. Brauer. Q. The question was merely whether you had an opinion.

The Court. That's right, let him answer.

A. Yes, sir.

Mr. Brauer. Q. Will you state your opinion?

A. In other words, if I had examined him for

an insurance company, I would have passed him. I would have okayed him.

Mr. Brauer. Now, may I have Exhibit 1, please?

Q. Dr. Sambuck, I show you Exhibit 1 in evidence and call your attention to parts B and C thereof and ask you whether you, at my request, have, during the past few days, looked at an exact copy of that part B and C?

A. I didn't get you——

Mr. Walsh. Just a moment, please.

Mr. Brauer. May I proceed, counsel?

Mr. Walsh. If your Honor please, I would like to move to strike out the opinion this doctor has given upon the grounds stated. As I understand your ruling, it was he could state whether or not he had an opinion.

The Court. Yes, that's right.

Mr. Walsh. Now I ask that the opinion that he gave in response to the next question be stricken, because obviously it does not relate to the time of the application and was an answer to the question that calls for his conclusion, and did not include the facts involved in this case.

The Court. I will reserve my ruling on that until I take the full case."

Error No. 23. The Court erred in refusing to allow Mr. Svendsen, Chief Underwriter of Appellant, to testify that the application, if completed, would have come to his division. The full substance of the evidence rejected and the grounds urged are as follows (R. 221-222):

"Mr. Walsh. Q. In the course of your duties as an underwriter, chief underwriter, Mr. Svend-

sen, if that application had been completed would it have come to your division?

A. That is right.

Mr. Boyle. Objection, Your Honor. Move to strike the answer.

Mr. Walsh. I fail to see the basis of these objections.

The Court. The objection will be sustained. I don't think it is material. I have let the record be encumbered with a great many objections on both sides here that I should have sustained, and now I am going to start to rule the way I think I should rule, without taking them under advisement.

We will go on from there. Go ahead.

Mr. Walsh. May the witness answer?

The Court. No.

Mr. Walsh. Well, Your Honor, we have an issue in this case, put in issue by the plaintiff, through oral testimony that was allowed on the plaintiff's side, evidence went far beyond the matters of negotiations and explanations. I made objection at that time, and the evidence was admitted. Now, if we are not entitled to introduce evidence to present our side of the case we are precluded from a proper defense of this action.

The Court. I think I have ruled correctly."

Error No. 24. The Court erred in refusing to allow Mr. Svendsen, Chief Underwriter of defendant, to testify in response to merely preliminary questions concerning the weight and height of an applicant. The full substance of the evidence rejected and the proceedings are as follows (R. 228):

"Mr. Walsh. Q. You have Plaintiff's Exhibit 1?

A. Yes, sir, right here.

Q. Will you turn to Part A of the application where it shows the classification? That's marked 'Intermediate'?

A. That's correct.

Mr. Boyle. Your Honor, the record here shows there are two marks in 'Classification'.

Mr. Walsh. It has been testified to that the correct marking was——

The Court. Yes, the marks have been explained.

Mr. Walsh. Q. Does the weight of an applicant, Mr. Svendsen, have anything to do with the classification?

A. Yes, sir.

Mr. Boyle. Objection, Your Honor: incompetent, irrelevant and immaterial; self-serving; hearsay; calling for the opinion and conclusion of the witness.

The Court. The answer may be stricken and the objection will be sustained."

ARGUMENT.

1. APPELLEE FAILED TO PROVE THAT A WRITTEN CONTRACT OF INSURANCE WAS IN FORCE AND EFFECT ON AUGUST 13, 1954, AT THE TIME OF GRANT'S DEATH.

A. An application for insurance amounts to a mere offer to enter into an insurance contract.

It is well settled that a contract requires the mutual consent of the parties or, as sometimes stated, a meeting of minds. The required meeting of minds occurs when one party makes an offer which is accepted by the other party according to its terms. The courts of

California have had occasion to discuss these fundamental principles. In *Linnastruth v. Mutual Benefit Assn.* (1943) 22 C.2d 216, at 219, 137 P.2d 833, at 834, the California Supreme Court said:

> "An application for insurance is a proposal. A meeting of minds is essential. And the proposal is not a completed contract until it is accepted by the insurer in the same terms in which the offer was made. If the acceptance modifies or alters any of the terms of the proposal, it must in turn be accepted by the applicant to be effective as a contract."

In *Burch v. Hartford Fire Ins. Co.* (1927) 85 C.A. 542, 259 P. 1108, the Court had under consideration an application for crop insurance which provided that the insurance applied for would not be binding until the application was approved and a policy delivered. The Court said:

> "Under such circumstances the application is but one of the purposes or steps leading to a contract of insurance. It requires action on the part of the insurer, to whom the application is made, before a binding contract can be created. In other words, there must be a meeting of the minds or a meeting of the mind of the applicant and the insurer."

The fundamental requirement in all contracts, including insurance contracts was stated in a practical way by a California court in *Standard Accident Ins. Co. v. Pratt* (1955) 130 C.A.2d 151, 278 P.2d 489. This case involved a suit for declaratory relief on an automobile

liability policy which involved alleged misrepresentations in the application. At page 155 the court said:

> "In 14 Cal. Jur. 422 it is said that the application is the proposal for insurance, and it is in reliance upon the facts stated in the application that the policy is usually issued and that an application is nothing more than a representation by a party when he applies for insurance."

The court, in *K.C. Working Chemical Co. v. Eureka-Security Ins. Co.* (1947) 82 C.A.2d 120, 185 P.2d 832 which involved two fire insurance policies, discussed the contractual aspects of insurance contracts at some length, citing many authorities. At page 131 the opinion states:

> "Until an application for insurance is accepted no contractual relation exists between an applicant for insurance and an insurance company (authorities cited). An insurance company is not bound to accept an application or proposal for insurance but may reject it for any reason or arbitrarily (authorities cited). A mere intention or mental determination on the part of the insurer to accept the application is not of itself sufficient to effect a binding contract (authorities cited)." (See also *Mutual Life Ins. Co. v. Young* (Calif. case) 90 U.S. 85, 106, 23 L.Ed. 152.)

These principles of contract are of fundamental importance and govern the decision in this action.

B. The application is one document but has several parts.

An examination of the application discloses that it is in pamphlet form and consists of four pages, three of which are entitled Parts A, B and C, respectively.

Appellant's witness, Alan Wigham, testified that the application (Ex. 1) is the form of application customarily used by the Company; that the writing agent completes Part A of the application; that Part A requires the signature of the applicant; that, after Part A is signed by the applicant, the agent puts the application in the hands of the medical examiner; that the doctor asks the applicant the questions contained in Part B of the application and records the applicant's answers therein; that the applicant is required to sign at the bottom of Part B to complete that part of the application; that the medical examiner fills in the answers to the questions on Part C of the application; that, after the application is placed in the hands of the medical examiner, it is sent by him, when completed, direct to the Appellant's Head Office and that the application would be returned by Appellant's Head Office if not signed by the applicant on both Parts A and B (R. 160-166).

A recent Federal District Court case involved a factual situation similar to that which exists in this action, *Corn v. United American Life Ins. Co.* (USDC, D. Colo.) 104 F.Supp. 612. The Court said, at page 613:

> "The Company's application for an insurance policy, which was submitted to Corn for completion, consisted, so far as it is pertinent here, of two printed forms. One of these forms was entitled 'Part One of Application for Insurance'; the other was headed, 'Part Two of Application for Insurance'."

Part One of the application was executed by the applicant and the Court notes that "It contained all the data required by the Company for the issuance of a policy, other than information concerning the health and physical condition of the applicant. Part Two, which was never filled out and which Corn never executed, was a medical or health questionnaire." The applicant never underwent his physical examination and never submitted or completed Part Two of the application for insurance before his death. In deciding that no insurance contract had been created, the Court, at page 615, stated as follows:

> "It must also be remembered that Part Two was actually an element of the application for insurance. Surely the parties did not intend coverage to be effected prior to the time it was fully applied for."

An application similar to the one in the instant case was construed by the Court in *Holden v. Metropolitan Life Ins. Co.,* 42 N.Y.Supp. 310; reversed on other grounds (160 N.Y. 647, 58 N.E. 771). Suit was brought to recover on the life insurance policy issued pursuant to the application and the company defended on the grounds of fraud in the application. On appeal the plaintiff took the position that the statements made in the second part of the application were not part of the contract of insurance. The application offered in evidence consisted of, first, questions and answers under the head of "Application to Metropolitan Life Insurance Company" which, at the end, was dated and signed by the applicant. Next came

questions and answers under the head of "Statements Made to the Medical Examiner" which, at the end, contained a statement called a "warranty" signed by the applicant. The Court noted that these statements were apparently on one sheet of paper which was endorsed "Application to Metropolitan Life Insurance Company". The Court rejected the plaintiff's argument that the term "application" as used in the policy included only the first part of the application and did not include the statements made to the medical examiner. The Court said:

> "Such application, consisting of several parts, must, I think, be deemed to be the application referred to in the policy, and therefore a part of the contract of insurance." (p. 113.)

In *Mutual Life Ins. Co. v. Hilton-Green,* 241 US 613, 60 L.Ed. 1202, at 241 US 621, 60 L.Ed. 1210, the Supreme Court construed an application consisting of several parts and observed: "The medical examiners' reports are plainly integral parts of application and by apt words the latter become an essential constituent of the policies." See also *Westphall v. Metropolitan Life Ins. Co.,* (1915) 27 C.A. 734, 151 P. 159.

Later herein we shall call particular attention to Appellant's application. It is clear that, so far as the applicant-offeror is concerned, both Part A and Part B must be signed by him and the completion of Parts A, B and C requires action on the part of the applicant.

C. Applicant knew he had to perform a condition precedent before insurance would become effective.

The evidence clearly establishes that Grant knew that a medical examination was required to complete the application for insurance. Price, when filling in Grant's answers to the questions in Part A of the application, had the application open before him. The application, which is four pages in pamphlet form, is always kept intact. (R. 70.) As Price wrote in the answers to the questions in Part A, the whole application was before them and Grant could see it and what was written in Part A of the application; he was sitting to the left of Price. (R. 69-70.) Grant read Part A before he signed it. (R. 217-218.) Hence, he was bound to know there was a Part B. Obviously, Part B pertained to a medical examination. In the upper right hand corner of Part A of the application appears the word "Medical". Throughout the printed matter in Part A of the application, directly above Grant's signature, are references to both Part A and Part B of "this" application.

Paragraph No. 1 says "The statements and answers in Part A and Part B of the application for this insurance shall form the basis of the contract of insurance, if one be issued."

Paragraph No. 2 refers to "medical examiner".

Paragraph No. 3 states "No statement to or by, and no knowledge on the part of, any agent, medical examiner or any other person as to any facts pertaining to the applicant shall be considered as having been made to or brought to the knowledge of the Company

unless stated in *either Part A or Part B* of the application for this insurance." (Our emphasis.)

Both Parts A and B are entitled "Application to the Metropolitan Life Insurance Company". Below this heading on Part B appears "Applicant's Statements to the Medical Examiner". At the bottom of Part B is a place for "the Signature of Applicant" below a certification which states as follows: "I have read the foregoing answers before signing. They have been correctly written as given by me and are true and complete. There are no exceptions to such answers other than as stated herein".

There is no question that Grant knew that the application had a Part B as well as a Part A and that a medical examination was required. The general rule is that, when a person with the capacity of reading and understanding an instrument signs it, he is bound by its conditions and is estopped from saying that its provisions are contrary to his intentions or understanding. (*Palmquist v. Mercer* (1954) 43 C.2d 92, 272 P.2d 26; *Currin v. Currin* (1954) 125 C.A.2d 644, 271 P.2d 61.)

Grant was told that he had to have a medical examination for this insurance—Price told him this on the evening of August 10, 1954. On the receipt given to Grant, Price filled in under the printing "Appointment for Medical Examination" the words "1st—small office * * * Not Thurs. * * * Dr. Blaisdell", explaining to Grant and Appellee that Dr. Blaisdell was Appellant's medical examiner, the location of his

office, and that the doctor was not in the office on Thursdays. That the parties clearly understood this is demonstrated by what happened on August 12, 1954. Appellee, Margaret Grant, testified on direct and cross-examination that, on that date, she made an appointment at Dr. Blaisdell's office for Mr. Grant to have his medical examination on August 13, 1954, at 3:30 in the afternoon. (R. 107, 130.)

The construction placed on a contract by evidence of the acts and conduct of the parties before any controversy has arisen as to its meaning is entitled to great weight.

Flax v. Prudential Life Ins. Co. of America (S.D.Calif. 1957) 148 F.Supp. 720;
Nicolaysen v. Pacific Home (1944) 65 C.A.2d 769, 151 P.2d 567;
Whalen v. Ruiz, 40 C.2d 294, 253 P.2d 457;
Corn v. United American Life Ins. Co., supra.

D. The evidence is undisputed that the application was not completed.

It is obvious from an examination of the application (Plf's Ex. 1, seven true and actual photostatic copies of which have been furnished to this Court) that the application was not completed by Grant. The only portion of the application which was filled in is Part A. At the time of death of Grant, the application was in the possession of Appellant's medical examiner in Watsonville, Dr. Blaisdell (R. 235), waiting for completion of Parts B and C.

Under California law there can be no insurance in force in such a situation.

Ransom v. Penn Mutual Life Ins. Co., 43 C.2d 420, 274 P.2d 633.

E. The language in Part A of the application and in the receipt does not create a contract for immediate insurance.

The District Court held that a contract of insurance was entered into between Appellant and Grant on August 10, 1954, said contract to take effect on August 11, 1954, and held that said contract was in full force and effect on August 13, 1954, the date of Grant's death. (R. 41-42.) In so doing, the District Court misconstrued the evidence and the law applicable to the evidence.

The law requires that every part of the contract be given effect and that the intention of the parties must be gathered from the whole thereof and not from an isolated or detached portion of the contract.

New York Life Ins. Co. v. Hiatt (9th Cir. 1944) 140 F.2d 752;

New York Life Ins. Co. v. Hollender (1951) 38 C.2d 73, 237 P.2d 510;

Corn v. United American Life Ins. Co., supra;

California Civil Code §1641, which provides as follows:

"EFFECT TO BE GIVEN TO EVERY PART OF CONTRACT. The whole of a contract is to be taken together, so as to give effect to every part, if reasonably practicable, each clause helping to interpret the other."

The evidence heretofore mentioned given by Appellee, that a medical examination was required "for this insurance", must also be given great weight when applying the rules of interpretation of contracts. Appellant urges that, in reading what is alleged to be a contract of insurance, the Court should consider all of Plaintiff's Exhibit 1, the Application, and all of Plaintiff's Exhibit 2, the Receipt. It seems clear, in considering the whole of these two documents, that no contract for immediate insurance was made.

(1) The parties did not intend immediate insurance.

The evidence establishes that there was no intention of the parties that Peter Grant would be covered by insurance on August 11, 1954.

The primary purpose in construing the writings is to determine and give effect to the mutual intention of the parties as it existed at the time of contracting.

> *New York Life Ins. Co. v. Hollender,* supra; *Thomas v. Buttress & McClellan, Inc.* (1956) 141 C.A.2d 812, 297 P.2d 768.

No representations were made by the agent as to when the insurance would become effective. The applicant knew that the application had not been completed and that a medical examination was required. The Appellee herself testified that Price told Grant that he had to have a medical examination for the insurance and she made the appointment for her husband for this medical examination. Her testimony and her conduct in making the appointment for her husband, before any controversy arose, makes the inten-

tion of the parties crystal clear. The evidence concerning the discussion about a medical examination and Mrs. Grant's making the appointment with Dr. Blaisdell warrants only one inference, namely, that she was acting as agent for Peter Grant, her husband, when she made the appointment. Appellee is bound by her testimony which establishes that the applicant knew there was a condition precedent to be performed, which only the applicant himself could perform, i.e., the submission to a medical examination for the insurance.

In *Hutchinson v. Metropolitan Life Ins. Co.* (Mo. 1956) 293 S.W.2d 307, the plaintiff and alleged beneficiary testified concerning the medical examination. The Court observed:

> "Plaintiff says that '*we* knew they must want it for a reason' but *she* 'didn't think anything about it'. That testimony does not constitute evidence that Mr. Hutchinson did not know and fully understand the purpose and significance of the examination." (p. 313.)

In the present action Appellee made it clear, by her own testimony, that she understood the purpose and significance of the examination. She testified that Price told Grant, in her presence, that he *had to have* a medical examination *for this insurance.* (R. 130.) Appellee herself has conclusively established the intention of the parties.

(2) Conditions precedent exist which were not performed.

The evidence that Grant knew the application consisted of at least two parts and that he had to submit

to a medical examination, and that an appointment was made by his agent for him to have the medical examination, establishes that Grant understood that more was required of him than just the completion of Part A and accepting the receipt, before insurance became effective. The application was not completed. The medical examination was not taken. Hence, there was nothing that could be approved at the home office.

The language in paragraph 4, just above the signature of Peter Grant in Part A of the application, states:

> "4. The Company shall incur no liability under this application until a policy has been delivered and the full first premium specified in the policy has actually been paid to and accepted by the Company during the lifetime and continued insurability of the applicant, in which case such policy shall be deemed to have taken effect as of the date of issue as recited therein, except as follows: *If* an amount equal to the full first premium on the policy applied for is paid to and accepted by the Company at the time Part A of this application is signed and *if* this application is approved at the Company's Home Office for the class, plan and amount of insurance herein applied for, *then* the insurance in accordance with the terms of the policy applied for shall be in force from the date hereof." (Our emphasis.)

The language in the receipt is to the same effect, except it adds:

> ". . . *but otherwise* no insurance shall be in force under said application unless and until a policy has been delivered . . ." (Our emphasis.)

and also provides for refund of the premium if the policy is not delivered within 60 days. This language clearly states payment of the *full* first premium as a condition precedent, and *approval* of the application at the Company's Home Office of the class, plan and amount of insurance as further conditions precedent. Approval means what it says.

Kammerer v. Metropolitan Life Ins. Co. (Ga. Ct. of App., 1957) 98 S.E.2d 391.

The application was not approved at the Company's Home Office at all. It received it only after Grant's death, and then it was only partially completed. The uncompleted application, at the time of death, was in the possession of the Company's medical examiner and, about a week later, was sent to the Home Office of Appellant without any premium. (R. 235.) There is no conflict in the evidence on these facts. The failure of Peter Grant to take the medical examination, as required, was non-performance by him of a true condition precedent to the obligation of Appellant. (3 Williston on Contracts, Rev. Ed. §666A.) Grant knew he had to submit to a medical examination "for this insurance" and he was the only one who could do it.

Many rights under a contract of insurance relate to the "in-force date of the insurance contract", such as the premium chargeable based on the attained age of the insured, the commencement of the incontestable period, determination of loan value, reserve basis, dividends, extended insurance, paid-up insurance,

cash surrender value, application of the suicide clause, etc. (*Lloyd v. Franklin Life Ins. Co.* (9 Cir., 1957) 245 F.2d 896.) The advantages of the conditional receipt to Peter Grant are easily illustrated.

The facts reveal that, on August 11, 1954, Peter Grant was over 35 years old (born February 19, 1919) and that, nine days after August 11, 1954, his attained age (age nearest birthday) would have increased by one year. (Part A of the application, Ex. 1.) It is a matter of common knowledge that life insurance premiums increase with age, and other rights and obligations change or modify accordingly. It should be pointed out that, if the full first premium had been paid and the completed application had been approved, Peter Grant's life would have been insured at age 35 and not at 36, even though it took more than nine days to process the application. On a whole life policy the saving in premiums could amount to hundreds of dollars. The conditional receipt protects the applicant for insurance against the contingency of sickness or death intervening its date and the delivery of the policy, if the application for insurance is accepted.

Hyder v. Metropolitan Life Ins. Co. (S.C., 1937) 190 S.E. 239.

De Cesare v. Metropolitan Life Ins. Co. (Mass., 1932) 180 N.E. 154, cited with approval and distinguished in *Hyder v. Metropolitan Life Ins. Co.,* supra. (Both cases involved conditional receipts nearly identical with Appellant's receipt given to Peter Grant.)

Parties to insurance contracts, as in other contracts, have the right to fix the time when and conditions upon which insurance shall be in force and such time may be prior to, at the time of, or subsequent to the delivery of the policy.

Potts v. Metropolitan Life Ins. Co. (Pa., 1938) 2 A.2d 870, cited with approval in *Lloyd v. Franklin Life Ins. Co.,* supra.

F. In a situation such as this no life insurance company has ever been held liable. Similar cases hold there is no insurance in force.

In *Hyder v. Metropolitan Life Ins. Co.,* supra, the facts are that a written application was made by the father of a nine-year-old boy. The receipt given the plaintiff was almost identical with the receipt given by Appellant in this action. The boy died before a medical examination and before the application had been sent to the Home Office. At the time of death the application was on the desk of the examining physician of the Company. Upon the conclusion of the plaintiff's case in the trial court, the defendant moved for a nonsuit, but the motion was denied. Although the plaintiff attempted to prove an oral contract of insurance, based on alleged statements of the insurance company's agent, the trial court sustained objections to this testimony and tried the case on the theory that the issue to be determined was whether the application and receipt constituted a written contract of insurance. In overruling the motion for nonsuit and in his charge to the jury, the trial judge made certain comments in regard to the purpose and

effect of a conditional receipt. The jury brought in a verdict for the plaintiff. The Appellate Court reversed and held that the conditions laid down in the receipt were conditions precedent and that the motion for nonsuit should have been granted. In connection with the remarks of the trial judge, the Appellate Court said at 245:

> "We do not think that his honor has correctly construed this binding receipt. He plainly states that the receipt does not mean what it says. We think it does. He interpolates into it language and conditions which are not in it. This interpretation of the binding receipt is not in accord with the interpretations given such receipts in this jurisdiction, and the majority of other jurisdictions, including the federal courts."

The Court distinguished cases such as *Cantor v. Life Ins. Co.* (S.C., 1933) 168 S.E. 848; *De Cesare v. Metropolitan Life Ins. Co.,* supra, on the ground that in those cases the application was completed, received by the company's home office, and approved.

The facts in *Mofrad v. New York Life Ins. Co.* (10 Cir., 1953) 206 F.2d 491, also disclose the applicant died prior to the completion of the application and taking a medical examination. As in the instant case, the agent advised the applicant that he would have to have a physical examination and, in fact, made several appointments with authorized physicians for the applicant. The applicant did not have the physical examination, apparently due to the press of personal matters. The Court said at 493:

"And there are no provisions in the agreement which would lead to a conclusion that an interim contract was intended by the parties. There are other clearly prescribed conditions within the agreement than the payment of the premium and delivery of the receipt to the applicant, which lead only to the conclusion that the applicant was merely applying for a contract of insurance which could be consummated only upon the fulfillment of the conditions set out in the application. And where a policy application contains such conditions precedent, performance thereof is a prerequisite to the taking effect of insurance coverage. (Citing authorities.)

* * *

"But appellants argue that unless the insurance began on the date of the application, as specified in Part 3, the premium would cover a period during which the company did not assume the risk, and the insured would be paying for insurance for a period when he was not insured.

"The application for the policy provided that the insurance policy should be dated as of the date of the application. 'It was within the rights of, and was competent for, the parties to provide in the application under what conditions and at what time the policy should become effective and binding.' *Jones v. New York Life Ins. Co.* (1927), 69 Utah 172, 253 P. 200, 202. The provisions in the application agreement do not fix the effective date of the insurance contract. They simply impose conditions precedent to the taking effect of the insurance coverage. (Authority cited.)

* * *

"We must conclude that the applicant failed to meet the required conditions precedent to the consummation of an insurance contract, and the judgment of the trial court is affirmed."

In *Corn v. United American Life Ins. Co.,* supra, the company's application consisted, so far as is pertinent, of two printed forms, one of which was entitled "Part One of Application for Insurance"; the other was headed "Part Two of Application for Insurance". The applicant executed Part One of the application in the presence of the company's agent. Part Two was a medical or health questionnaire. At the time Part One was signed the applicant gave the agent a check to cover the first year's premium on the anticipated policy. At the same time, the applicant suggested to the agent that he desired to have the physical examination on or about January 20, 1948. The agent agreed to this arrangement. The applicant failed to have the physical examination on January 20, 1948, and, although the company wrote him several letters, he never had the physical examination and Part Two of the application for insurance was never submitted. On February 16, 1948, the applicant was killed in an airplane accident.

In its opinion the Court said at page 615:

"There is some confusion among the authorities as to the legal effect of the arrangement disclosed by the record herein. From a study of these decisions, the Court is satisfied that many of the seeming conflicts and the conclusions reached therein may be accounted for by the factual dif-

ferences in the terms of the individual contracts involved. The Court, therefore, believes that each contract for interim insurance should be measured on its own merits and in the light of its own particular wording. (Citing cases.) * * * An ordinary common sense interpretation of the critical clause in the receipt reveals that the word 'provided' was used in the sense of 'if'. Insurance was to take effect as of January 15, 1948, *if* Part Two was promptly completed and the remaining conditions were met. (Citing authorities.)

"In addition, it must be remembered that the completion of Part Two of the application required the taking of a medical examination and the submission to the Company of the data revealed by that examination together with a urine specimen and a medical history. In other words, the first condition in the proviso required acts on the part of Corn rather than acts or a state of mind on the part of the Company. The Restatement of Contracts, section 260, comment b, expresses unequivocally that:

> 'Any clause . . . in a policy of insurance requiring any act to be done by the insured, will make that act a condition of the covenant or promise of insurance.'

It must also be remembered that Part Two was actually an element of the application for insurance. Surely the parties did not intend coverage to be effected prior to the time it was fully applied for."

* * *

"Diligent search has failed to reveal a single authority which recognizes the existence of in-

terim insurance where the alleged insured himself had failed to take steps upon which the agreement of the parties conditioned liability.

"In addition, it should be pointed out that at the time Corn passed away, the Company had no knowledge of his physical condition. When Part One was completed, Wilder informed Corn that Part Two had to be executed and that this required a physical examination. Besides that, the Company mailed Corn three letters in a period of less than one month, urging him to take the examination, when it appeared that he was procrastinating about the matter. Under those circumstances, it is not readily conceivable that the Company intended to insure Corn, or that Corn understood the Company to intend to insure him, without any knowledge of his physical status."

Appellant's application and receipt both provide, in effect, that, after the conditions precedent are performed, *"then"* the insurance in accordance with the terms of the policy applied for shall be in force from "this date" (the receipt) or the date of Part A. The effect of this is to fix the time to which the insurance relates after the conditions precedent have been performed. When Appellant's application and the receipt are construed together, it plainly appears that insurance may become effective by one of two methods. First, if "a policy has been delivered and the full first premium specified in the policy has actually been paid to and accepted by the Company during the lifetime and continued insurability of the applicant". Second, "if an amount equal to the full first premium on the policy applied for is paid to and accepted by the Com-

pany at the time *Part A of this application* is signed and *if this application* is approved at the Company's Home Office, the class, plan and amount of insurance herein applied for, *then* the insurance . . . etc." A holding that insurance was in force, even though the application was not completed, the physical examination was not had, and the completed application and full first premium payment were not received at the Company's Home Office, nullifies completely the plain meaning of the words used in the application and receipt and ignores the law on this subject.

In the *Corn* case, supra, Part 2 of the application is the medical part equivalent of the Metropolitan's Part B medical part. Over the signature of the applicant in Part 1 of the application in the *Corn* case is the printed statement "This application including part 2 hereof, which part 2 I agree to complete promptly as the Company may require . . ."

The Appellant's receipt in the instant case, when construed with the application, makes it equally clear that Grant was to take a medical examination "for this insurance". The receipt has the following printed and written matter:

"Appointment for Medical Examination

* 1st—small office

Date * not Thurs.

* Dr. Blaisdell

Between the hours of.....and.....or P.M."

Note: * In handwriting of Mr. Price.

The interpretation placed upon that by Grant himself is that he had to go to Dr. Blaisdell for a medical examination "for this insurance". (R. 105-107, 130.)

Therefore, the *Corn* case and the instant one are identical on interpretation.

G. Under a California statute a receipt does not become binding until a completed application is approved.

In 1949 the California Legislature enacted Insurance Code § 10115. The statute is set forth in full in Appendix B of this brief. The section states under what circumstances a conditional receipt may effect a binding contract of insurance. It states, in effect, when a payment is made equal to the full first premium at the time an application for life insurance is signed by the applicant and the applicant receives at that time a receipt for said payment on a form prepared by the insurer, and if the insurer *approves* the application for the plan and for the class of risk and amount of insurance applied for, and the applicant dies on or after the date of the application, the date of the medical examination, if any, or after the date specially requested in the application for the policy to take effect, *whichever is later,* but before such policy is issued and delivered, the insurer shall pay such amount as would have been due under the terms of the policy subject to the same rights, conditions and defenses as if such policy had been issued and delivered on the date such application was signed by the applicant.

This statute gives applicants for life insurance certain rights as a matter of law. (*Lloyd v. Franklin Life*

Ins. Co., supra.) Moreover, it is an expression of the Legislature as to what constitutes fair dealing between insurance companies and applicants for life insurance. The statute recognizes the right of the insurance company to *approve* of the application before death as to the plan and for the class of risk and amount of insurance applied for. This recognition of the validity of the "approval" requirement is applicable in this case.

This section recognizes as conditions precedent to liability of the insurance company payment of the full first premium, "approval" and a *medical examination.* The conditions were not performed in this case because Grant failed to perform conditions which only he could perform. The language in Part A of Appellant's application and of Appellant's receipt fully advised Grant of his rights under the law of California.

Plaintiff's Exhibit 2 (R 245) is not a "binding receipt". It is not labelled at all. It is a receipt with conditions. Insurance Code § 10115 states under what circumstances a receipt for payment of a life insurance premium shall be considered to be a binding receipt, i.e., binding as a contract of insurance. A comparison of § 10115 and Appellant's receipt reveals that Appellant's receipt was not "binding" and that no insurance could exist by virtue of the receipt until all of the conditions precedent were fully performed. Appellant's receipt states that *if* a condition is performed, and *if* another condition is performed, *then* insurance shall be in force, *but otherwise no insurance shall be in force* unless and until a policy is deliv-

ered and a full first premium is paid to and accepted by the Company during the lifetime and continued insurability of the applicant. Appellant's receipt, as does Ins. Code § 10115, first sets forth the conditions precedent and *then* refers to the insurance company's obligation to pay. Application of the provisions of said statute to the facts herein lead to only one conclusion, namely, that the Judgment of the District Court is against the law.

H. Ransom v. Penn Mutual Life Ins. Co. is not a precedent in this case.

The District Court, in its memorandum of opinion, said:

> "I find very little difference in this case and the case of *Ransom vs. Penn Mutual Life Insurance Company,* (Calif.) 274 P.2d 633." (R. 37.)

We respectfully submit that, contrary to the opinion of the District Court, there are *many* differences between this case and *Ransom v. Penn Mutual Life Ins. Co.,* supra. These differences compel a reversal of the Judgment of the District Court.

In the *Ransom* case the California Supreme Court merely held that, under the particular language in the *Penn Mutual* application, a contract of insurance arose only upon the receipt at the home office of the insurance company of the *completed application* (including the medical) and the full first premium.

(1) An entirely different application and receipt are involved in this case.

In the *Ransom* case the Court construed language contained in the application of *Penn Mutual*. (Apparently, only the form of the receipt for payment of the first premium was before the Court.) The *Penn Mutual* application contained the following clause:

> "If the first premium is paid in full in exchange for the attached receipt signed by the Company's agent when this application is signed the insurance shall be in force, subject to the terms and conditions of the policy applied for, from the date of Part I or Part II of this application, whichever is the later, provided the Company shall be satisfied that the Proposed Insured was at that date acceptable under the Company's rules for insurance upon the plan at the rate of premium and for the amount applied for, but that if such first premium is not so paid or if the Company is not satisfied as to such acceptability, no insurance shall be in force until both the first premium is paid in full and the policy is delivered while the health, habits, occupation and other facts relating to the Proposed Insured are the same as described in Part I and Part II of this application and in any amendments thereto." (43 C.2d at 423.)

Note that, at the very beginning of the *Penn Mutual* clause, it states that:

> "If the first premium is paid in full . . . when this application is signed the insurance *shall be in force,* . . ." (Our emphasis.)

and thereafter is wording concerning conditions, one of which the Court held to be a condition subsequent.

In contrast to the above, the *Metropolitan's* application (Paragraph 4 of Part A of Exh. 1) reads as follows:

> "*If* an amount equal to the full first premium . . . is paid . . . at the time *Part A of this application* is signed and *if this application* is approved at the Company's Home Office . . . *then* the insurance . . . shall be in force . . ." (Our emphasis.)

There is nothing following this that is or can be construed as a condition subsequent.

The equivalent language is in the *Metropolitan's* receipt (Exh. 2, R. 245), but we do not have to emphasize it because the Appellant did so when the forms were printed. (See underlining.)

The Court, in *Hyder v. Metropolitan Life Ins. Co.,* supra, had before it a receipt almost exactly like Appellant's here. The Court held that there was no insurance in force until the application had been approved by the Company's Home Office. The Court also discussed *Stanton v. Equitable Life Assurance Society* (S.C., 1926) 135 S.E. 367, which was concerned with a receipt similar to the *Penn Mutual* clause. That receipt stated that insurance would take effect "provided the applicant is, on this date, in the opinion of the Society's authorized officer in New York, an insurable risk under its rules, and the application is otherwise acceptable on the plan and for the amount and at the rate of premium applied for." The Court noted that the *Stanton* case receipt differed radically from the one before it and, after quoting the

language contained in the *Stanton* case receipt (190 S.E. at 248), said: "Note the glaring differences between this receipt and that in our present case."

Each application and receipt should be measured on its own merits and in the light of its own particular wording.

Corn v. United American Life Ins. Co., supra.

(2) Whenever Appellant's application or receipt have been construed by the Courts they have been held to be clear and unambiguous.

Another distinction between the *Ransom* case, supra, and this one is that in the *Ransom* case the Court found ambiguity in the *Penn Mutual* application.

Here the situation is different. The District Court from which this appeal is taken found no ambiguity in the Appellant's application or receipt. Where other jurisdictions have interpreted the *Metropolitan's* applications and receipts those Courts have held them to be clear and unambiguous.

Kammerer v. Metropolitan Life Ins. Co., supra;
Hyder v. Metropolitan Life Ins. Co., supra.

The Court, in *Hyder v. Metropolitan Life,* supra, had before it for consideration a receipt of Appellant's which, in all material respects, was the same as the receipt in the present action. The Court said, at 190 S.E. 245:

> "We think there is no ambiguity about this receipt. It means just what it says, viz: If the application is forwarded to the home office and approved for the class, plan, and amount of insurance applied for, the insurance is of force from the date of the receipt; and it follows that,

if the applicant dies after that date and before the issuing and delivering of the policy, his insurance will be paid. If no binding receipt is given, then the contract of insurance is not effective until the policy is issued and delivered during the lifetime of the insured."

Where the terms of a contract of insurance are plain and explicit, it must be interpreted according to its plain meaning and that Court will not indulge in a forced construction so as to cast a liability upon the insurance company which it has not assumed.

Lloyd v. Franklin Life Ins. Co., supra;
Home Indemnity Co. v. Standard Accident Ins. Co. (9th Cir. 1948) 167 F.2d 919;
New York Life Ins. Co. v. Hollender, supra;
Blackburn v. Home Life Ins. Co. (1941) 19 C.2d 226, 120 P.2d 31.

(3) The facts in this case are different from those in Ransom v. Penn Mutual.

Here Grant never took a medical examination and, consequently, Parts B and C of Appellant's application (Exh. 1) *could not be completed* or sent to the Home Office.

In the *Ransom* case the applicant did take a medical examination so that the application *was completed* and sent to the Home Office. It was only under those *facts* that the Court held a contract of insurance arose.

The District Court, in this case, erred in failing to find facts on a material issue which should have made a difference in the outcome of this case.

NOTE: Up to this point we have covered substantiolly Specification of Errors Nos. 1, 2, 4, 8, 9, 15, 16, 17, 18, 19, 20 and 21.

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2. APPELLEE FAILED TO PROVE THAT APPELLANT, AT ITS HEAD OFFICE, AUTHORIZED AND APPROVED PETER GRANT FOR INSURANCE AS TO THE BUSINESS IN WHICH HE WAS ENGAGED.

There is no evidence to support the allegation in the second cause of action of Appellee's First Amended Complaint to the effect that Appellant, on August 11, 1954, accepted a premium payment "after having previously secured from its home office an approval of said contract of insurance for the class, plan and amount of insurance provided for in said contract". (R. 26.) The District Court found on this issue only that:

> "On or before August 10, 1954, defendant, at its head office, authorized and approved Peter Grant for insurance as to the business in which he was engaged." (R. 39-40, Finding VII.)

This indicates that the District Court concluded that Appellee did not prove her allegations (R. 26, top of page) of prior approval by Appellant at its home office for the class, plan and amount of insurance applied for. Furthermore, Finding No. VII, concerning approval as to the "business", is erroneous because the evidence is to the contrary. Appellant's Exs. A, B, C, D, E and F and Appellee's 5 indicate Appellant at its Home Office had certain information prior to August 10 and 11, 1954, but those exhibits

conclusively prove that the home office did not approve anything before those dates. The sum and substance of the evidence is that knowledge of the nature of Grant's business, a crop-duster, was acquired by the Home Office and it said it would have to view the *completed papers* before taking action. (Ex. D, R. 253; 171, 172-187; 181-182; 193-194.)

The Home Office was first asked by its District Office if an application could be submitted on Grant for $5,000.00 additional insurance. (Dft's Ex. A; R. 250.) Grant then had a $5,000.00 policy issued in 1950 before he became a crop-duster. (R. 174.) After obtaining a completed aviation questionnaire, Appellant advised its District Office, by letter of July 20, 1954, that it could "consider" Peter Grant for insurance. (Ex. D; R. 253.) In that letter Appellant made it clear that it could not promise to issue a policy until it viewed the completed papers, suggesting that an application be completed and a medical examination be arranged between Peter Grant and an authorized medical examiner.

There is nothing in this case that can be construed as an approval by Appellant of Peter Grant for insurance with respect to his occupation. Appellant merely advised its District Office that it could "consider" issuance of a policy to Grant when it viewed the completed papers. The letter of July 20, 1954, was shown to Grant (R. 193-194) and, in addition, he was put on notice, when he signed Part A of the application, that no agent, medical examiner or any person except the President, Vice Presidents, Actuaries,

Treasurers or Secretaries of the Company had power on behalf of the Company (a) to make, modify or discharge any contract of insurance, or (b) to bind the Company by making any promises respecting any benefits under any policy. (Ex. 1, Part A.)

The evidence is that an application (and not just a "trial" application) must be submitted to the Home Office. (Ex. D.) Appellant made this clear in its letter of July 20, 1954 (Ex. D), when it required that the application be completed, a medical examination be taken, a mercantile report ordered in the usual manner, and that the "completed papers" be viewed at the Home Office. In any event, it is unbelievable that Grant, a businessman who was already the owner of a life insurance policy issued by Appellant, could have thought that all that was necessary for him to obtain additional life insurance was to have the Appellant authorize and approve him as to his occupation. The evidence establishes that Grant knew otherwise.

The foregoing also applies to Specification of Error No. 14, namely, the failure of the District Court to make a Finding on a material issue as set forth in paragraph 14, page 238 of Record.

3. APPELLEE FAILED TO PROVE THAT APPELLANT FULLY INFORMED ITSELF OF PETER GRANT'S NEEDS AND DESIRES FOR LIFE INSURANCE. APPELLEE FAILED TO PROVE THAT APPELLANT FULLY INFORMED ITSELF OF OTHER FACTORS BEARING UPON GRANT'S ACCEPTABILITY AS AN INSURANCE RISK AND THE TERMS UPON WHICH SUCH RISK WOULD BE ASSUMED BY APPELLANT.

A. Peter Grant inquired about various plans of insurance of the face amount of $5,000.00.

The evidence clearly establishes that, prior to the death of Grant, Appellant had *knowledge* that Grant was considering only $5,000.00 of Whole Life insurance.

Appellant first received a trial application on a $5,000.00 Whole Life Paid-Up at Age 85 policy. Appellant was next advised that Grant was interested in Family Income with Whole Life Paid-Up at Age 85 and was still interested in $5,000.00 on this plan. At the time of Grant's death, the incomplete application (Ex. 1) was in the hands of Appellant's medical examiner in Watsonville. It was not until after Grant's death that the uncompleted application was sent to Appellant's Head Office and that Appellant had any knowledge that Grant was considering more than $5,000.00 face amount of Whole Life insurance. These facts are undisputed.

B. Authority of Appellant's agent was limited.

In Part A of the application (Ex. 1), directly over the signature of Peter Grant, is a statement to the effect that no agent, medical examiner or any other person (except certain officers of the Company) has power on behalf of the Company to make, modify or

discharge any contract of insurance or to bind the Company by making any promises respecting any benefits under any policy issued thereunder.

Said Part A, directly over the signature of Grant, also contains a statement to the effect that no statement made to or by, and no knowledge on the part of any agent, medical examiner or any other person as to any facts pertaining to applicant shall be considered as having been made to or brought to the knowledge of the Company unless stated in either Part A or Part B of the application for insurance.

Such limitations of the authority of an agent are proper and, when Grant signed Part A of the application, notice was thereupon given him of the limitation of the authority of the agent, medical examiner and any other person and Grant was bound by such notice.

Winslow v. Mutual Life Ins. Co. (9 Cir., 1938), 93 F.2d 802;

New York Life Ins. Co. v. Fletcher, 117 U.S. 519, 529, 29 L.Ed. 934;

Iverson v. Metropolitan Life Ins. Co., 151 C. 746, 91 P. 609;

Toth v. Metropolitan Life Ins. Co., 123 C.A. 185, 11 P.2d 94;

Lucas v. Metropolitan Life Ins. Co., 14 C.A.2d 676, 58 P.2d 934;

Hutchinson v. Metropolitan Life Ins. Co., supra.

C. Appellant had no knowledge of the medical condition of Peter Grant.

Appellant had no knowledge of the medical history or health of Grant, either before or after his death. Grant did not have a medical examination by Appellant's medical examiner, Part B of the application, "Applicant's Statements to the Medical Examiner", was not completed, nor was the medical examiner's report (Part C of the application) completed.

So prevalent is the practice among life insurance companies to require a complete physical examination and medical history before issuing a policy of the amount here involved that it seems unnecessary to argue that these are important factors bearing upon Grant's acceptability as an insurance risk. Appellant had no knowledge of these factors.

D. Finding of Fact No. V is erroneous. That portion of the finding attacked is too broad.

Appellant did not have full knowledge of Grant's needs and desires for life insurance and was not fully informed of "other important factors bearing upon his acceptability as an insurance risk", and was not fully informed of the "terms upon which such risk would be assumed". Grant was advised that no statement or knowledge on the part of any agent or medical examiner as to any facts pertaining to Grant were made to or brought to the knowledge of the company unless stated in either Part A or Part B of the application for insurance. Parts B and C were not completed. The Appellant had not "viewed" the "completed papers". (Ex. D; R. 253.)

Finding of Fact No. V is prejudicially erroneous and is not supported by the evidence.

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4. FINDING OF FACT NO. IX, TO THE EFFECT THAT APPELLEE AND PETER GRANT CONSTRUED THE APPLICATION AND RECEIPT AS EFFECTING A CONTRACT OF INSURANCE AND THAT SUCH CONSTRUCTION WAS REASONABLE IS CLEARLY ERRONEOUS AND CONTRARY TO THE EVIDENCE, AND STATES CONCLUSIONS AND NOT FACTS.

Peter Grant construed the application as requiring a medical examination as a condition precedent. Appellee's own evidence, hereinabove discussed and quoted, conclusively establishes that Price told Grant that he had to have a medical examination "for this insurance". (R. 130.) Concurrently, Price filled in the information concerning the medical appointment in the receipt, while discussing the medical requirement with Grant. (Ex. 2; R. 218; R. 71-75.) On August 12, 1954, Appellee, as agent for Peter Grant, made an appointment for him to submit to a physical examination by Dr. Blaisdell at 3:30 p.m., August 13, 1954. (R. 107, 130.) This evidence of the conduct of Grant by his agent, before any controversy arose, is entitled to great weight in determining the intentions of the parties and construing the application and receipt.

Corn v. United American Life Ins. Co., supra;
Flax v. Prudential Ins. Co. of America, supra;
Nicolaysen v. Pacific Home, supra.

Appellee, on cross-examination, retracted her statement to the effect that she and Peter Grant "as-

sumed" that the insurance was in force when the premium was paid. She then testified as to her personal assumption, saying "I assumed". (R. 129.) That was merely a conclusion of one not a party to a contract.

The retraction leaves no evidence of Grant's assumption and the inference is that he did not so assume. Furthermore, his action in arranging to see Dr. Blaisdell indicates a contrary intent. "Actions speak louder than words", and actions certainly speak much louder than any unexpressed assumption.

In *Zurich Assurance Co. v. Industrial Acc. Com.*, 132 C.A. 101, 103, 22 P.2d 572, 573, the Court said:

> ". . . the law imputes to a person an intention corresponding to the reasonable meaning of his words and acts. It judges of his intention by his outward expressions and excludes all questions in regard to his unexpressed intention."

The last sentence of Finding of Fact IX says "Said construction was reasonable." This portion of the finding is a misplaced conclusion of law.

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5. THE DISTRICT COURT PREJUDICIALLY ERRED IN OVERRULING APPELLANT'S MOTION TO STRIKE THE OPINION OF DR. SAMBUCK.

Appellee's witness, Dr. Antone J. Sambuck, testified that he examined Peter Grant on June 8, 1954, as a medical examiner for the Civil Aeronautics Administration. Over Appellant's objection (R. 119), the District Court allowed Dr. Sambuck to testify that,

on June 8, 1954, he found Grant in good physical health. Again over Appellant's objection and motion to strike, Dr. Sambuck was allowed to testify that, based on his examination of Peter Grant on June 8, 1954, and all his experience as a life insurance medical examiner, his opinion was that, if he had examined Grant for an insurance company, he would have okayed him. (R. 120-122.)

There was no issue in this case concerning Grant's physical condition on June 8, 1954. The date of the application (Part A) was August 11, 1954. Proper objection was made. The testimony of Dr. Sambuck that, after reading Parts B and C of Exhibit 1, he did not note any derogatory information as of June 8, 1954, was irrelevant and the objection on that ground should have been sustained. (R. 122-124.) Grant's health on June 8, 1954, is too remote in time to show his health on August 10, 1954. Another reason the evidence was immaterial is that Part A of the application and the receipt did not condition the effectiveness of the desired insurance entirely on the good health of Peter Grant; rather, it conditioned such effectiveness on the approval of the completed application at the home office and payment of the full first premium.

None of Dr. Sambuck's testimony has any probative value, anyhow. He admitted he knew nothing about Appellant's insurance requirements and stated that he did not know whether Appellant would have approved Peter Grant for insurance. (R. 126-127.) Dr. Sambuck didn't see Grant after June 8, 1954. (R. 114-115.)

The foregoing relates to Specification of Error No. 22.

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6. SPECIFICATION OF ERROR NO. 6.

The Finding No. VI (R. 39), to the effect that up to and including August 13, 1954, Grant enjoyed excellent health and suffered no disability, infirmity or ailment is erroneous and contrary to the evidence for the following reasons:

1. There is not a scrap of evidence in the record that Grant was in "excellent health" at any time.

2. Dr. Sambuck's testimony, as pointed out above, carries no weight and portions should have been stricken. His examination also was remote in time.

3. Appellee's Ex. 6, Dr. Sambuck's Medical Certificate (not a certificate of insurance as he testified—R. 119, last three lines) for the C.A.A., shows a "physical deficiency". (R. 249.)

4. Appellee's testimony is that Grant had stomach trouble in July 1954. (R. 114.)

5. The only other evidence is the Appellee's, as a lay witness, that her husband was in good health on August 10, 11, 12 and 13, 1954.

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7. SPECIFICATIONS OF ERRORS NOS. 3, 10 AND 12. CERTAIN FINDINGS OF FACT CONTAIN MISPLACED CONCLUSIONS OF LAW AND UNNECESSARY FACTS.

Finding of Fact No. II (R. 38), wherein it states "Plaintiff is . . . the beneficiary *named in the contract*

of insurance sued upon" is erroneous in that it states as a fact what is properly a conclusion, the existence of a contract of insurance between Grant and Appellant.

The same error appears in Finding of Fact No. X (R. 40-41), wherein it refers to "said contract of insurance" and in Finding of Fact No. XII (R. 41), wherein it states "Said contract of insurance provided . . ."

The question raised by the pleadings is whether there was a contract of insurance. In *Hunter v. Sparling* (1948) 87 C.A.2d 711, 721, 197 P.2d 807, 813, the Court said:

> "From these basic facts the question is presented, is plaintiff entitled to recover the sum of $20,835.50, plus interest, from defendant? That is a question of law and not of fact. The question as to whether, from the facts found, there was a contract, . . . or any other legally enforceable obligation, is a question of law and not of fact. For that reason the 'finding' that the rules and regulations relating to retirement formed no part of plaintiff's contract of employment is not a finding of fact at all but a misplaced conclusion of law, not supported by the facts found, which facts are practically undisputed. The rule applicable to such a situation is well settled. Where a conclusion of law is not supported by the facts found, the conclusion of law must be disregarded." (Cases cited.)

In the instant case all portions of the Findings of Fact to the effect that there was a "contract of insurance" should be disregarded.

All of Finding of Fact No. X should be disregarded. It states (R. 40):

> "At no time prior to the death of Peter Grant did the defendant perform any act or communicate an intention to rescind or terminate said contract of insurance."

This "finding" anticipates the District Court's conclusion. Rescission of a contract of insurance was not an issue before the Court. No such defense was raised by Appellant's Answer to the First Amended Complaint. Finding of Fact No. X is unnecessary, improper and prejudicial to Appellant. As we have already demonstrated, there was no contract of insurance in force on August 13, 1954. It follows that there could be no act or communication by Appellant of an "intention to rescind or terminate said contract of insurance."

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8. SPECIFICATION OF ERROR NO. 11.

The Court erred in finding as a fact that portion of Finding No. XI (R. 41) that Grant died

> ". . . solely as the result of an accident while engaged in his occupation hereinbefore mentioned."

Said finding is erroneous and not supported by the evidence and is not an issue in this case. The issue as to how Grant died was raised in the first cause of action in the First Amended Complaint, but this was dismissed. (R. 34.) It is admitted by the Appellant in its Answer that Grant died August 13, 1954. (R. 33.) Appellee testified he died in the morning of that

day. (R. 107.) Counsel for Appellant was careful not to stipulate as to the manner of death. (R. 108-112.) There should be no finding such as the one mentioned above in this case, which might be construed as res judicata in another suit on a policy such as the one mentioned in the first cause of action of the First Amended Complaint, especially where said first cause of action has been dismissed herein.

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9. SPECIFICATION OF ERROR NO 13.

The Court erred in failing to make a finding on a material issue, namely, that on August 14, 1954, Grant's check for $53.36 was returned to Margaret L. Grant by the Appellant and she accepted it, and no tender has ever been made of any amount of money since then to the Appellant on account of the application for insurance. (See paragraph 13, R. 238.)

It is undisputed that the check was returned and she accepted it. It was also stipulated that, after the check was returned and accepted on August 14, 1954, no tender has ever been made of any amount of money since then to the Appellant on account of the premium on the application. (R. 134-135.)

10. EVIDENCE CONCERNING APPROVAL WAS ARBITRARILY EXCLUDED.

We come now to the discussion of Errors Nos. 23 and 24.

Specification of Error No. 23 has to do with the District Court's refusing to allow Mr. Svendsen, Chief Underwriter of Appellant, to testify that the application, if completed, would have come to his division.

It must be remembered that one of the conditions precedent to insurance in this case is approval of the completed application at the Home Office of the Company as to the class, plan and amount of insurance applied for. Nevertheless, the District Court refused to allow Mr. Svendsen to testify that the application, if completed, would have come to his division. He is the Chief Underwriter. The soliciting agent is not an underwriter. The question put to Mr. Svendsen was a preliminary one, but the Court refused to allow an answer. (For the proceedings see R. 221-222.)

Specification of Error No. 24 is that the Court erred in refusing to allow Mr. Svendsen to testify that the weight of an applicant had anything to do with the classification of the applicant.

In the plaintiff's case below, the Court had allowed Dr. Sambuck to testify as to the weight and height of Grant on June 8, 1954. (R. 124-125.) Based upon those facts, and others recited by Dr. Sambuck, said doctor was allowed to give his opinion as to the insurability of Grant. (R. 121.) It is a matter of common knowledge that there is a relationship between height and weight. Tables and charts on this have been sup-

plied to the public in numerous magazine articles and other publications. Nevertheless, the District Court refused to allow Mr. Svendsen to reply to a preliminary question: "Does the weight of an applicant, Mr. Svendsen, have anything to do with the classification?" (R. 228.) Again, it must be borne in mind that, under Appellant's application and receipt, approval at the Home Office of the class of insurance is a condition precedent to any insurance being effective. Examination at the Home Office of the completed application might have disclosed that Grant had to be classified above "Intermediate", and the application might have been rated up or rejected for that reason alone. This line of inquiry, however, was foreclosed by the District Court's ruling.

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11. **THE PREMIUM.**

Neither the application nor the receipt specifies that the $53.36 was the full first premium. (Ex. 1, No. 23(a) and Ex. 2.) In fact, Part A of the application says that the $53.36 "has been paid in advance *on account of the first premium*". The receipt says the $53.36 is "received" on "account of application . . ."

Apparently, Price made "approximate computations" (R. 215) of the premium and, therefore, the full first premium was not paid. However, Appellant was not allowed to prove the correct premium. (R. 222-226.)

It is undisputed that Appellant has no premiums.

CONCLUSION.

The record undisputably shows that Appellant, at its Home Office in San Francisco, had not, prior to August 10 or 11, 1954, approved any contract of insurance, the subject matter of this action, for the class, or the plan, or the amount of insurance applied for in Exhibit 1; nor had it approved any such insurance as to the business of the applicant, Peter Grant. (See Appellant's Exhibits A through G, all of which were properly admissible in evidence regardless of whether they were or were not shown to Mr. Grant.)

Likewise, the record, beyond dispute, shows that Peter Grant knew, on the evening of August 10, 1954, that he had to go and have a medical examination by Appellant's examining physician, Dr. Blaisdell. Obviously, the purpose of that examination was to complete the application and supply Appellant with essential information necessary for it to consider the risk. The risk in this case, at best, was a hazardous one. The applicant was a crop-duster. Mr. Grant's knowledge of the necessity of a medical examination and the intention of both parties to the documents that a medical was necessary "for this insurance" arose out of the plain terms and conditions of the application and the receipt, and the handwriting in the receipt, and the discussion had that evening with Mr. Price. The Appellee herself testified to that discussion as an explanation of said handwriting concerning Dr. Blaisdell.

Mr. Grant was not inexperienced in matters of this kind. In 1950 he had gone through the process of ob-

taining a $5,000.00 policy of life insurance from Appellant and he also had a National Service life insurance policy for $10,000.00 on the term plan since 1943. (See Ex. 1, Part A, No. 20.) He was a man of substance, earning $15,000.00 per year (see back of Ex. 1). He was a businessman. He and Mrs. Grant operated the business in Watsonville for Atwood Crop Dusters of Salinas, California. (R. 138, 141.) He knew the difference between a "policy in force" and an application. (R. 106.)

Mr. Grant hastened to deposit money in the bank on August 11, 1954. That demonstrates that he knew he had to cover the check. That was a condition he had to perform. Likewise, he arranged with his wife, as his agent, to make an appointment with Dr. Blaisdell. That also demonstrates that he knew the medical examination was another condition on his part to be performed. He never performed that condition and, therefore, his omission prevented completion of the application before his death and the approval of the application at Appellant's Home Office. Mr. Grant, therefore, failed to fulfill one of the conditions upon which the agreement of the parties conditioned liability. Obviously, the medical examination had to be taken before Mr. Grant died. It could not be otherwise.

The precise factual situation presented by this case has never been ruled upon by any reported decision of the Supreme or Appellate Courts in California, to our knowledge, but, as pointed out above, other jurisdictions have encountered no difficulty in holding that

the Appellant's application and receipt are clear and unambiguous and, under situations such as this, have held that there is no insurance in force at the time of the applicant's death.

It is respectfully submitted that the Judgment of the District Court should be reversed and Judgment entered in favor of the Appellant.

Dated, San Francisco, California,
February 10, 1959.

Respectfully submitted,
KNIGHT, BOLAND & RIORDAN,
BURTON L. WALSH,
JOHN J. QUIGLEY,
Attorneys for Appellant.

(Appendices A and B Follow.)

Appendices A and B.

Appendix A

EXHIBITS

Plaintiff's Exhibits	Identified	Offered and Received	Offered and Rejected
1	58-60	63	
2	61-62	63	
3	63-64	64	
4	64-65	65-66	
5	95-96	96	
6	119-120	120	
Defendant's Exhibits			
A	171	171	
B	171	171	
C	171	171	
D	171	171	
E	171-172	172	
F	172	172	
G	172	172	
H	230-231	231, 234	

Appendix B

CALIFORNIA INSURANCE CODE §10115

§10115. *Binders; death of insured before issuance of policy.* When a payment is made equal to the full first premium at the time an application for life insurance other than group life insurance is signed by the applicant and either (1) the applicant received at that time a receipt for said payment on a form prepared by the insurer, or (2) in the absence of such a receipt the insurer receives the said payment at its home office, branch office, or the office of one of its general agencies, and in either case the insurer, pursuant to its regular underwriting practices and standards, approves the application for the issuance by it of a policy of life insurance on the plan and for the class of risk and amount of insurance applied for, and the person to be insured dies on or after the date of the application, on or after the date of the medical examination, if any, or on or after any date specially requested in the application for the policy to take effect, whichever is later, but before such policy is issued and delivered, the insurer shall pay such amount as would have been due under the terms of the policy in the same manner and subject to the same rights, conditions and defenses as if such policy had been issued and delivered on the date the application was signed by the applicant. The provisions of this section shall not prohibit an insurer from limiting the maximum amount for which it may be liable prior to actual issuance and delivery of the policy of life

insurance either to (1) an amount not less than its established maximum retention, or to (2) fifty thousand dollars ($50,000.00), if a statement to this effect is included in the application.